MDR Tracking Number: M5-04-1030-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 06-03-03.

The IRO reviewed prescriptions for Valium, Lorcet, Biofreeze/IL, Aloe Vera GE and durable medical equipment rendered on 10-18-02 and 10-25-02 that was based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the requestor **did not prevail** on the issues of medical necessity.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 03-24-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	NDC CODE	Billed	Paid	EOB Denial Code	Reference	Rationale
4-29-02 5-16-02 and 7-21-02 (3 DOS)	00140000601	$188.90 on 4-29-02 and 5-16-02, $196.60 on 7-21-02 (Total of $574.40)	$0.00	F	96 MFG PHARMACEUTICAL GR (I)(B)	Requestor submitted proof of out of pocket expenses and proof of request for reimbursement to respondent. Reimbursement recommended in the amount of $574.40
5-16-02 and 7-15-02 (2 DOS)	00785635001	$138.03 on 5-16-02 and $150.34 on 7-15-02 (Total of $288.37)	$126.52 Paid on 7-15-02 DOS	F	96 MFG PHARMACEUTICAL GR (I)(B)	Requestor submitted proof of out of pocket expenses and proof of request for reimbursement to respondent. Additional reimbursement recommended in the amount of $161.85

DOS	NDC CODE	Billed	Paid	EOB Denial Code	Reference	Rationale
6-13-02 and 6-28-02 (2 DOS)	No information available	$196.60 on 6-13-02 and $150.34 On 6-28-02 (Total of $346.94)	No information available	NO EOB	96 MFG PHARAMACEUTICAL GR (I)(B)	Requestor did not submit proof of out of pocket expenses nor proof of submission to respondent. No reimbursement recommended.
TOTAL		$1,210.00	$126.52			Requestor is entitled to reimbursement in the amount of $736.00

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 04-29-02 through 07-21-02 in this dispute.

This Findings and Decision and Order are hereby issued this 12th day of May 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

NOTICE OF INDEPENDENT REVIEW DECISION

Date: March 17, 2004

MDR Tracking #: M5-04-1030-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic reviewer (who is board certified in Orthopedic Surgery) who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

The claimant has a history of chronic right wrist pain allegedly related to a work compensable injury that occurred on or about ___. The claimant sustained a Kales fracture. Subsequently the claimant underwent a wrist reconstructive procedure on 7/31/97. Current diagnoses include: malunion, chronic pain syndrome, traumatic arthritis, right wrist.

Requested Service(s)

Valium, Durable medical equipment (TENS), Lorcet, Biofreeze, Aloe Vera Gel

Decision

I agree with the insurance carrier that the requested interventions are not medically necessary.

Rationale/Basis for Decision

Generally, long term use of durable medical equipment and medications in the treatment of chronic pain is indicated when there has been a clinical trial to determine effectiveness in significantly increasing objective parameters including, but not limited to, range of motion, increase in functional capacity and a decrease in the need for the use of other medical services. In a letter of medical necessity dated January 2, 2003 the treating physician states that the medications and durable medical equipment help the claimant to perform activities of daily living. Upon review of all information provided, there is no documentation of objective measurement of range of motion or functional capacity prior to onset of use of medications and durable medical equipment and after use of medications and durable medical equipment to indicate any significant improvement over time with the use of the medications and durable medical equipment. The use of narcotics for chronic pain is to be discouraged. When they are considered medically necessary, there should be documentation of a medication management agreement in place. There must be periodic assessment of VAS scores, and as with the other treatment modalities under review, a functional assessment of efficacy. Additionally, there should be periodic attempts at weaning of the medication, to assure lowest therapeutic dosing. These requirements are absent from the provided documentation. Generally, chronic pain due to posttraumatic arthritis is managed with oral anti-inflammatory medication, bracing, and physical therapy emphasizing a home exercise program and conventionalized heat modalities. There is no documentation of exhaustion of conservative measures of treatment including, but not limited to, oral non-steroidal and steroidal anti-inflammatory medications, bracing, and physical therapy emphasizing dynamic stabilization, home exercise program, and the use of ice/heat modalities.